

**STATE OF MICHIGAN**  
**DEPARTMENT OF LABOR & ECONOMIC GROWTH**  
**OFFICE OF FINANCIAL AND INSURANCE SERVICES**  
**Before the Commissioner of Financial and Insurance Services**

In the matter of

XXXXX

Petitioner

File No. 86883-001

v

Paramount Care of Michigan, Inc.  
Respondent

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Issued and entered  
This 8<sup>th</sup> day of February 2008  
by Ken Ross  
Acting Commissioner

**ORDER**

**I**  
**PROCEDURAL BACKGROUND**

On January 2, 2008, XXXXX, on behalf of her 13 year old son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On January 9, 2008, after a preliminary review of the material submitted, the Commissioner accepted the request.

The case required analysis by a medical professional. Therefore, the Commissioner assigned the matter to an independent review organization (IRO) which submitted its recommendation to the Office of Financial and Insurance Services on January 24, 2008.

**II**  
**FACTUAL BACKGROUND**

On September 13, 2007, the Petitioner's mother called their primary care physician's office because Petitioner was having trouble breathing, was coughing, and experiencing severe pain in his ears. The answering machine at the doctor's office instructed callers who were

experiencing an emergency to go to the emergency room. Petitioner's mother considered her son's symptoms and past history of pneumonia and concluded that he required emergency care. She took him to the emergency room at XXXXX Hospital in XXXXX.

The Petitioner requested coverage from Paramount for the emergency room care provided on September 13, 2007. Paramount denied coverage, saying the Petitioner's condition did not require urgent or emergency care and could have been provided on an outpatient basis.

Following the Petitioner's appeal, Paramount issued a final adverse determination letter dated December 5, 2007.

### **III ISSUE**

Did Paramount properly deny coverage for the Petitioner's September 13, 2007 emergency room services?

### **IV ANALYSIS**

#### **Petitioner's Argument**

According to Petitioner's mother, their doctor's office was closed when she called. (The emergency room records show Petitioner arriving there at 8:38 PM.) Petitioner's mother says she followed the telephone instructions that advised her to seek care from the emergency room. The emergency room physician who examined the Petitioner diagnosed him with acute left otitis media and acute bronchitis. The Petitioner argues that the care should be covered because she did as directed in the doctor's telephone answering service message.

#### **Respondent's Argument**

In its December 5, 2007, final adverse determination, Paramount stated that it would "uphold the original denial of payment for the ER as the presenting signs and symptoms of fever, ear pain, cough and congestion are not considered to be an emergency medical

condition. Please see page 20 and 21 of the Subscriber Certificate and Member Handbook which discusses emergency medical conditions.”

### Commissioner’s Review

The Commissioner carefully reviewed the arguments and documents presented by the parties in this case. The focus of this analysis is whether Paramount properly denied coverage for emergency room services received September 13, 2007.

Paramount does provide coverage for emergency services when medically necessary and appropriate based on the definition of an “emergency medical condition” as found in the federal prudent layperson legislation. Pages 20 and 21 describe emergency medical conditions and include the following provisions:

### **WHAT TO DO FOR URGENT CARE OR EMERGENCY MEDICAL CONDITIONS**

#### **Urgent Care Services**

\* \* \*

**After office hours:** Call the telephone number of your PCP and ask the answering service to have your doctor call you back. When the doctor or a nurse calls back, explain your condition, and the doctor or nurse will give you instructions. If you can’t call your PCP [primary care physician], go to the nearest medical facility. The service will be subject to an emergency room, urgent care facility, or office visit Copayment depending on where you receive treatment. Your copayment is stated in your Summary of Benefits.

\* \* \*

#### **Emergency Services**

Emergency Services are those services which are required as the result of an Emergency Medical Condition. Emergency Medical Condition means a medical condition that manifests itself by such acute symptoms of severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn Child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

To answer the question of whether it was medically necessary for the Petitioner to seek treatment in the emergency room, the Commissioner assigned the case to an IRO for analysis. The IRO reviewer is board certified in emergency medicine and is published in peer-reviewed medical literature and is in active practice.

The IRO report includes the following analysis and conclusions:

The prudent layperson's rule would apply in this case; the PCP's office was closed and the recording stated "If you feel you have an emergency then go to the nearest emergency department. . ." and the mother complied with the instructions. The prudent lay person rules are guidelines for non-medical people to avoid delay in seeking medical care. There is not a substantial amount of variation with degrees of intended emergency status. The recording stated "if you feel" based on the symptoms in question, in this case difficulty breathing, then the layperson acts on these symptoms. Cough, in most layperson's eyes, is a symptom or an impending symptom of difficulty breathing.

The Commissioner notes that Michigan law, MCL 500.3406k, requires that insurers and HMOs include emergency care provisions in their policies and certificates of coverage:

- (1) An expense-incurred hospital, medical, or surgical policy or certificate delivered, issued for delivery, or renewed in this state that provides coverage for emergency health services and a health maintenance organization contract shall provide coverage for medically necessary services provided to an insured for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An insurer shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization. An insurer shall not deny payment for emergency health services up to the point of stabilization provided to an insured under this subsection because of either of the following:
  - (a) The final diagnosis.
  - (b) Prior authorization was not given by the insurer before emergency health services were provided.
- (2) As used in this section, "stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner because it is based on extensive experience, expertise, and professional judgment. It is also consistent with the provision of Michigan law quoted above. The Commissioner can discern no reason why the IRO's judgment should be rejected in the present case and finds that Paramount's denial should be reversed.

## **V ORDER**

Paramount's December 5, 2007, final adverse determination is reversed. Paramount is required to provide coverage for the Petitioner's September 13, 2007 emergency room treatment, subject to any applicable copayments or deductibles. Paramount shall provide coverage within 60 days and provide the Commissioner proof it has implemented this order no later than seven days from the date of payment.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.